CANCER INCIDENCE IN MASSACHUSETTS

1998 – 2002:

CITY AND TOWN SUPPLEMENT

Center for Health Information, Statistics, Research, and Evaluation

Massachusetts Department of Public Health

November 2005

CANCER INCIDENCE IN MASSACHUSETTS

1998 – 2002:

CITY AND TOWN SUPPLEMENT

Mitt Romney, Governor
Kerry Healey, Lieutenant Governor
Timothy R. Murphy, Secretary of Health and Human Services
Paul J. Cote, Jr., Commissioner of Public Health

Gerald F. O'Keefe, Director, Health Information Systems
Susan T. Gershman, MS, MPH, PhD, CTR, Director, Massachusetts Cancer Registry

Center for Health Information, Statistics, Research, and Evaluation
Massachusetts Department of Public Health

ACKNOWLEDGMENTS

This report was prepared by Susan T. Gershman, Director, Massachusetts Cancer Registry, and Massachusetts Cancer Registry staff and consultants. Special thanks to Helen A. Hawk and Annie MacMillan for their diligent work in the preparation of this report. Thanks are also given to Laurie MacDougall, M.S. Consultant and the staff of the Massachusetts Cancer Registry for their editing and data processing efforts.

Massachusetts Cancer Registry Staff

Susan T. Gershman, M.S., M.P.H., Ph.D., C.T.R., *Director*

Troy C. Arthur, C.T.R., *Cancer Registrar*
Bertina Backus, M.P.H., *Epidemiologist*
Donna Barlow, L.P.N., C.T.R., *Cancer Registrar*
Bruce Caldwell, *Research Analyst/Geocoder*
Nancy Donovan, M.A., O.T.R., C.T.R., *Cancer Registrar*
Patricia J. Drew, C.T.R., *Cancer Registrar*
Helen A. Hawk, Ph.D., *Epidemiologist*
Loi Huynh, *Software Developer*
Ben Jackson, *Systems Analyst*
Regina Kenney, *Data Acquisition Coordinator*
Mary Jane King, M.P.H., C.T.R., *Acting Assistant Director of Registry Operations*
Ann MacMillan, M.P.H., *Epidemiologist*
Ruth Maranda, L.P.N., C.T.R., *Cancer Registrar*
Mary Mroszczyk, C.T.R., *Geocoding/Special Projects Coordinator*
Sadie Phillips-Scott, *Administrative Assistant*
Judith Raymond, C.T.R., *Cancer Registrar*
Pamela Shuttle, C.T.R, R.H.I.T., *Cancer Registrar*
Hung Tran, *Software Developer*
Donna J. Vincent, R.H.I.A., *Geocoder*

Massachusetts Cancer Registry Advisory Committee

Nancy Mueller, Sc.D., *Chair*

Suzanne Condon, M.S.
Frederick Li, M.D.
Regina Mead
J. David Naparstek, Sc.M., C.H.O.
Philip Nasca, Ph.D.
Susan O'Hara, C.T.R.
Robert Osteen, M.D.
David Ozonoff, M.D., M.P.H.
Carol Rowan-West, M.P.H.
Lawrence Shulman, M.D.
Carol Venuti, C.T.R.

For further information, please contact the following:

Massachusetts Cancer Registry	(617) 624-5658
Research and Epidemiology	(617) 624-5635
Occupational Health Surveillance	(617) 624-5626
Center for Environmental Health	(617) 624-5757
Cancer Prevention and Control Initiative	(617) 624-5070
Massachusetts Department of Public Health website	<www.mass.gov/dph>

We acknowledge the Centers for Disease Control and Prevention for its support of the staff and the printing and distribution of this report under cooperative agreement U55/CCU521937-01 awarded to the Massachusetts Department of Public Health. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention.

TABLE OF CONTENTS

INTRODUCTION

Content

The purpose of this report is to provide an estimate of cancer incidence for each of the 351 cities and towns of Massachusetts for the five-year time period 1998 through 2002. For each city and town, Standardized Incidence Ratios (SIRs) are presented for twenty-three types of cancer and for all cancer types combined. These ratios compare the cancer incidence experience of each city or town with the cancer experience of the state as a whole. The method involves comparing the number of cases that were observed for a city or town to the number of cases that would be expected if the city or town had the same cancer rates as the state as whole. The report is organized into the following sections:

NEW IN THIS REPORT provides an explanation of new items relevant to this report such as new coding schemes and definitions for defining types of cancers, new data sources, and methodological changes for calulating SIRs presented in this report.

METHODS provides a detailed explanation of the data collection, data processing and statistical techniques employed in this report.

TABLES present data for selected types of cancer by city/town and sex.

APPENDIX I provides a listing of International Classification of Diseases for Oncology codes used for the preparation of this report.

APPENDIX II provides a listing of risk factors for selected cancer types and a listing of the individuals who reviewed the risk factor list.

Comparison with Previous Reports

This report updates previous annual reports published by the Massachusetts Cancer Registry (MCR). It is available on line at http://www.mass.gov/dph/bhsre/mcr/canreg.htm. For questions about the report, contact the MCR at:

Massachusetts Cancer Registry
Center for Health Information, Statistics, Research and Evaluation
Massachusetts Department of Public Health
250 Washington Street, 6th floor
Boston, MA 02108-4619
telephone 617-624-5658; fax 617-624-5695

The preceding report ***1996-2000 City and Town Supplement*** included data for diagnosis years 1996 through 2000. This report contains data for the diagnosis years 1998-2002 and contains several changes from the previous report that are described in the section entitled **New In This Report**. It is important to note that due to these changes, standardized incidence ratios (SIRs) presented in this report cannot be compared with SIRs in the ***1996-2000 City and Town Supplement.***

NEW IN THIS REPORT

Implementation of International Classification of Diseases for Oncology, Third Edition

The International Classification of Diseases for Oncology, Third Edition (ICD-O-3) was implemented in North America with cases diagnosed as of January 1, 2001. Cancer cases diagnosed before this date were classified according to the International Classification of Diseases for Oncology, Second Edition (ICD-O-2). With the advance of diagnostic techniques over the past decade, the International Agency for Research on Cancer (IARC) and the cancer division of the World Health Organization (WHO) found it necessary to revise and update the International Classification of Diseases for Oncology, Second Edition (ICD-O-2). As a result, the new edition (ICD-O-3) contains more specific information about certain cancers. The most important changes between the second and the third editions include:

- Certain hematopoietic diseases are now considered to be malignant, where previously they were classified as 'uncertain whether benign or malignant.'
- Some neoplasms (mainly ovarian tumors) previously coded as malignant now revert to 'uncertain whether benign or malignant.'
- All cancer cases in MCR database diagnosed prior to January 1, 2001, originally coded in ICD-O-2 were converted to ICD-O-3, following the national rules of conversion.

Addition of New Data Sources

Beginning with cases diagnosed in 2001, the MCR began to collect reports from dermatologists' offices (about 230 offices) and dermatopathology laboratories (2 laboratories). In 2002, the MCR started to receive case reports from a limited number of urologists' offices and a general laboratory. *Because of this change, the number of cases of melanoma, and to a lesser extent, prostate cancer, and the "all sites combined" category will be higher compared to previous reports. As more urologists' offices begin to report cases, the prostate cancer numbers will also increase.*

Revised Definition of Urinary Bladder Cancer

Invasive and *in situ* cases of urinary bladder cancer are included in this report. This is consistent with national standards of presenting cancer incidence data. Prior to this report, only invasive cases of urinary bladder cancer were included in this category. Invasive cancers have spread beyond the layer of cells where they started and have the potential to spread to other parts of the body. *In situ* cancers are neoplasms diagnosed at the earliest stage, before they have spread, when they are limited to a small number of cells and have not invaded the organ itself.
The number of cases of bladder cancer and the all sites combined category will be higher compared to previous reports because of this change.

Change in Methodology for Calculation of Standardized Incidence Ratios (SIRs)

The expected number of cases and SIRs presented in this report were calculated using aggregated statewide and city and town population estimates for 1998-2002, stratified by five-year age groups for males and females. This is consistent with national standards for the calculation of rates and is consistent with the method used in the statewide annual report '*Cancer Incidence and Mortality in Massachusetts*' produced by the MCR. The rates and expected number of cases in previous reports were based on a mid-year population estimate and six broader age groups. *The results obtained using these two methods may differ slightly.* See the Methods section for a detailed explanation.

Presentation of 95% Confidence Intervals

A 95 percent confidence interval has been presented for each SIR in this report (when the observed number of cases is at least 5), to indicate if the observed number of cases is significantly different from the expected number, or if the difference may be due solely to chance. See the Methods section for a detailed explanation of confidence intervals.

Confidence intervals serve as an indicator of the significance and precision of the SIR. Prior to this report, the significance of SIRs was calculated at three levels of significance ($p<=.05$, $p<=.01$, and $p<=.001$); however the confidence intervals were not presented.

METHODS

Data Collection

Massachusetts cancer incidence data are collected by the Massachusetts Cancer Registry (MCR). The MCR is a population-based cancer registry that was established by state law in 1980 and began collecting data in January 1982. Currently, the MCR collects information on *in situ* and invasive cancers and benign tumors of the brain and associated tissues. The MCR does not collect information on basal and squamous cell carcinomas of the skin.

The MCR collects reports of newly diagnosed cancer cases from all Massachusetts acute care hospitals and one medical practice association (76 reporting facilities). In the year 2001, the MCR started to collect reports from dermatologists' offices (230 offices) and dermatopathology laboratories (2 laboratories). In 2002, the MCR started to receive case reports from urologists' offices and a general laboratory.

The MCR also collects information from reporting hospitals on cases diagnosed and treated in staff physician offices when this information is available. Not all hospitals report this type of case, however, and some hospitals report such cases as if the patients had been diagnosed and treated by the hospital directly. Collecting this type of data makes the MCR's overall case ascertainment more complete. The cancer types most often reported to the MCR in this manner are prostate cancer and melanoma.

To improve case completeness, this MCR report includes previously unreported cancer cases that have been discovered through death certificate clearance. This process identifies cancers mentioned on death certificates that were not previously reported to the MCR. In some instances, the MCR was able to obtain additional information on these cases through follow-up activities with hospitals, nursing homes and physicians' offices. In other instances, a cancer-related cause of death recorded on a Massachusetts death certificate is the only source of information for a cancer case. These "death certificate only" cancer diagnoses are, therefore, poorly documented, and have not been confirmed by review of complete clinical information. Such cases are included in this report, but they comprise less than 3% of all cancer cases for the years covered by this report.

Each year, the North American Association of Central Cancer Registries (NAACCR) reviews cancer registry data for quality, completeness, and timeliness. For diagnosis years 1998-2001, the MCR's annual case count was estimated by NAACCR to be more than 95% complete each year. The MCR achieved the gold standard for this certification element, as well as in six other quality and timeliness elements for each year from 1998-2001. Certification results for the year 2002 have not yet been released. The NAACCR method requires comparison with national incidence and mortality data, which are not yet available for the year 2002.

During the time period from 1998 to 2000, case reports were coded following the International Classification of Diseases for Oncology, Second Edition (ICD-O-2) system (1). The International Classification of Diseases for Oncology, Third Edition (ICD-O-3) was implemented in North America with cases diagnosed as of January 1, 2001 (2). For the data to be comparable, all cancer cases diagnosed prior to January 1, 2001, and coded in ICD-O-2, were converted to ICD-O-3, following the Surveillance, Epidemiology and End Results (SEER) rules of conversion (3). ICD-O-3 implementation led to some changes in cancer site definitions (See Appendix I for current definitions).

The Massachusetts data summarized in this report were drawn from cancer cases entered on MCR computer files before January 29, 2005 and from death certificate clearance activities completed in October 2004. The numbers presented in this report may change slightly in future reports, reflecting late reported cases or corrections based on subsequent details from the reporting facilities. Such changes might result in slight differences in numbers and rates in future reports of MCR data, reflecting the nature of population-based cancer registries that receive case reports on an ongoing basis.

Massachusetts cancer cases presented in this report are primary cases of cancer diagnosed among Massachusetts residents during 1998-2002. The Massachusetts data presented include invasive cancers only (except cancer of urinary bladder where *in situ* cancers are also included). Invasive cancers have spread beyond the layer of cells where they started and have the potential to spread to other parts of the body. *In situ* cancers are neoplasms diagnosed at the earliest stage, before they have spread, when they are limited to a small number of cells and have not invaded the organ itself. Typically, published incidence rates do not combine invasive and *in situ* cancers due to differences in the biologic significance, survival prognosis and types of treatment of the tumors. Cancer of the urinary bladder is the only exception, due to the specific nature of the diagnostic techniques and treatment patterns.

Presentation of Data

Each city and town in Massachusetts is listed alphabetically in the **TABLES** section. The observed number of cases, the expected number of cases, the standardized incidence ratios, and 95% confidence intervals are presented for twenty-three main types of cancer and for all cancer types combined. The 'all cancers combined' category includes the twenty-three main types presented in this report and other malignant neoplasms. This category is meant to provide a summary of the total cancer experience in a community. As different cancers have different causes, this category does not reflect any specific risk factor that may be important for this community.

Observed and Expected Case Counts

The *observed* case count (**Obs**) for a particular type of cancer in a city/town is the actual number of newly diagnosed cases among residents of that city/town for a given time period.

A city/town's *expected* case count (**Exp**) for a certain type of cancer for this time period is a calculated number based on that city/town's population distribution (by sex and among eighteen age groups) for the time period 1998-2002, and the corresponding statewide average annual age-specific incidence rates.

Standardized Incidence Ratios

A Standardized Incidence Ratio (SIR) is an indirect method of adjustment for age and sex that describes in numerical terms how a city/town's cancer experience in a given time period compares with that of the state as a whole.

- An SIR *of exactly* 100 indicates that a city/town's incidence of a certain type of cancer is equal to that expected based on average age-specific incidence rates.
- An SIR of *more than 100* indicates that a city/town's incidence of a certain type of cancer is *higher than expected* for that type of cancer based on statewide average annual age-specific incidence rates. For example, an SIR of 105 indicates that a city/town's cancer incidence is 5% higher than expected based on statewide average annual age-specific incidence rates.
- An SIR of *less than 100* indicates that a city/town's incidence of a certain type of cancer may be *lower than expected* based on statewide average age-specific incidence rates. For example, an SIR of 85 indicates that a city/town's cancer incidence is 15% lower than expected based on statewide average annual age-specific incidence rates.

Statistical Significance and Interpretation of SIRs

The interpretation of the SIR depends on both how large it is and how stable it is. Stability in this context refers to how much the SIR changes when there are small increases or decreases in the observed or expected number of cases. Two SIRs may have the same size but not the same stability. For example, an SIR of 150 may represent 6 observed cases and 4 expected cases, or 600 observed cases and 400 expected cases. Both represent a 50 percent excess of observed cases. However, in the first instance, one or two fewer cases would change the SIR a great deal, whereas in the second instance, even if there were several fewer cases, the SIR would only change minimally. When the observed and expected numbers of cases are relatively small, their ratio is easily affected by one or two cases. Conversely, when the observed and expected number of cases are relatively large, the value of the SIR is stable.

A 95 percent confidence interval has been presented for each SIR in this report (when the observed number of cases is at least 5), to indicate if the observed number of cases is significantly different from the expected number, or if the difference is most likely due to chance. A confidence interval is a range of values around a measurement that indicates how precise a measurement is. In this report, the 95% confidence interval is the range of estimated SIR values that has a 95% probability of including the true SIR for a specific city or town. If the 95% confidence interval range does not include the value 100, then the number of observed cases is significantly different from the expected number of cases. 'Significantly different' means there is at most a 5% chance that the difference between the number of observed and expected cancer cases is due solely to chance alone. If the confidence interval does contain the value 100, there is no significant difference between the observed and expected numbers. Statistically, the width of the interval reflects the size of the population and the number of events; smaller populations and smaller observed numbers of cases yield less precise estimates that have wider confidence intervals. Wide confidence intervals indicate instability, meaning that small changes in the observed or expected number of cases would change the SIR a great deal.

Examples:

- SIR = 137.0; 95% CI (101.6 - 180.6) – the confidence interval does not include 100 and the interval is above 100, indicating that the number of observed cases is statistically significantly higher than the expected number.

- SIR = 71.0; 95% CI (56.2 – 88.4) – the confidence interval does not include 100 and the interval is below 100, indicating that the number of observed cases is statistically significantly lower than the expected number.

- SIR = 108.8 95% CI (71.0-159.4) the confidence interval DOES include 100 indicating that the number of observed cases is NOT significantly different from what is expected, and the difference is likely due to chance. When the interval includes 100, then the true SIR may be 100.

Example of Calculation of an SIR and its Significance

$$SIR = \frac{\text{OBSERVED CASES}}{\text{EXPECTED CASES}} X\ 100$$

The following example illustrates the method of calculation for a hypothetical town for one type of cancer and one sex for the years 1998-2002:

Age* Group	**Town X Population** (A)	**State Age-Specific Incidence Rate** (B)	**Town X Expected Cases** (C) = (A) x (B)	**Town X Observed Cases** (D)
00-04	74,657	0.0001	7.47	11
05-09	134,957	0.0002	26.99	25
10-14	54,463	0.0005	27.23	30
15-19	25,136	0.0015	37.70	40
20-24	17,012	0.0018	30.62	30
UP TO 85+	6,337	0.0010	6.34	8
		Total:	**136.5**	**144**

$$SIR = \frac{\text{Observed Cases}}{\text{Expected Cases}} X\ 100 = \frac{\text{(column D total)}}{\text{(column C total)}} X\ 100 = \frac{144}{136.5} X\ 100 \cong 106$$

Thus the SIR for this type of cancer in Town X is 106, indicating that the incidence of this cancer in Town X is 6% higher than the corresponding statewide average incidence for this cancer. However, the range for the 95% confidence interval (89-124) indicates that the true value may be as low as 89 or as high as 124. Also, since the range includes the value 100, it means that the observed number of cases is *not significantly higher or lower* than what is expected.

Whenever the number of observed cases is less than five, the corresponding SIR is neither calculated nor tested for statistical significance. This is indicated with an SIR of "not calculated" (nc). However, the number of observed and expected cases is shown in these circumstances.

Notes about Data Interpretation

The SIR is a useful indication of which disease categories have relatively high or low rates for a given community. These statistics, however, should be used with care. They may provide a starting point for further research and investigation into a possible health problem, but they do not by themselves confirm or deny the existence of a particular health problem. Many factors unrelated to disease etiology may contribute to an elevated SIR including demographic factors, changes in diagnostic techniques and data collection or recording methods over time, as well as the natural variation in disease occurrence.

When reviewing the data tables, it is important to keep in mind that an SIR compares the observed cancer incidence in a particular community with the expected incidence based on statewide average annual age-specific incidence rates. This means that *valid comparisons can only be made between a community and the state as a whole*. *SIRs for different cities and towns* ***CANNOT*** and ***SHOULD NOT*** *be compared to each other*. (Comparisons between two communities would be valid only if there were no differences in the age and sex distributions of the two communities' populations.)

Data Limitations

It should be emphasized that apparent increases or decreases in cancer incidence over time might reflect changes in diagnostic methods or case reporting rather than true changes in cancer incidence. Four other limitations must be considered when interpreting cancer incidence data for Massachusetts cities and towns: under-reporting in areas close to neighboring states; under-reporting for cancers that may not be diagnosed in hospitals; cases being assigned to incorrect cities/towns, and standardized incidence ratios based on small numbers of cases.

Border Areas and Neighboring States

Some areas of Massachusetts appear to have low cancer incidence, but this may be the result of under-reporting -- that is, a loss of cases diagnosed or treated in neighboring states that are not reported to the MCR. Presently the MCR has reciprocal reporting agreements with fifteen states -- Alaska, Arkansas, Connecticut, Florida, Maine, Mississippi, New Hampshire, New York, North Carolina, Rhode Island, South Carolina, Texas, Vermont, Wisconsin and Wyoming.

Cases Diagnosed in Non-Hospital Settings

During the time period covered by this report (1998-2002) the MCR's information sources for nearly all cancer cases were hospitals. Dermatologists' offices began reporting in 2001, and urologists' offices in 2002. Some types of cancer in this report are undoubtedly under-reported because they may be diagnosed by private physicians, private laboratories, health maintenance organizations or radiotherapy centers that escape hospital case identification systems. Examples may include melanoma of skin, prostate cancer, and certain hematologic malignancies such as leukemia and multiple myeloma. The extent of this under-reporting has not been determined exactly. However, the North American Association of Central Cancer Registries has estimated that the MCR's records are more than 95% complete for the period 1998-2001. Estimates for the year 2002 have not yet been released.

City/Town Misassignment

In accordance with standard central cancer registry procedures, each case reported to the MCR should ideally be assigned to the city/town in which the patient lived at the time of diagnosis, based on the address provided by the reporting hospital. In practice, however, a patient may provide the hospital with his/her mailing address (e.g., a post office box located outside the patient's city/town of residence); a business address; a temporary address (e.g., the patient is staying with a relative while receiving treatment and reports the relative's address as his/her own); or a locality or post office name (e.g., "Chestnut Hill" rather than "Boston", "Brookline" or "Newton"). In addition, if a patient has moved since being diagnosed, the hospital may report the patient's current address. Because of the large number of cases reported to the MCR, and because data are reported to the MCR via electronic media, most city/town case assignments are performed by an automated computer process. This simplified matching process may misassign some cases based on the reported locality name. When MCR staff become aware of such misassignments, the errors are corrected manually. Furthermore, in order to minimize such errors, cases from fifty geographic localities prone to city/town misassignment are reviewed manually by the MCR.

Small Numbers of Cases

Standardized incidence ratios based on small numbers of cases result in estimates that are very unstable. This is common when the population of a city or town is small or if the particular cancer type is rare. SIRs and statistical significance were not calculated when the number of observed cases for a specific category was less than five. In these instances, the observed and expected cases are presented in the tables *for qualitative comparison only*.

T A B L E S

A P P E N D I C E S

APPENDIX I: INTERNATIONAL CLASSIFICATION OF DISEASES FOR ONCOLOGY (THIRD EDITION) CODES USED FOR THIS REPORT [1]

Cancer Site / Type	Primary Site Codes	Histologic Type Codes [2]
Bladder, Urinary	C67.0 - C67.9	all except 9590 - 9989
Brain and Other Central Nervous System	C70.0 - C72.9	all except 9590 - 9989
Breast	C50.0 - C50.9	all except 9590 - 9989
Cervix Uteri	C53.0 - C53.9	all except 9590 - 9989
Colon / Rectum	C18.0 - C18.9, C19.9, C20.9, C26.0	all except 9590 - 9989
Esophagus	C15.0 - C15.9	all except 9590 - 9989
Hodgkin Lymphoma	C00.0 - C80.9	9650 - 9667
Kidney and Renal Pelvis [3]	C64.9, C65.9	all except 9590 - 9989
Larynx	C32.0 - C32.9	all except 9590 - 9989
Leukemia	C00.0 - C80.9 C42.0, C42.1, C42.4	9733, 9742, 9800 - 9820, 9826 9831 - 9948, 9963, 9964 9823, 9827
Liver and Intrahepatic Bile Ducts	C22.0, C22.1	all except 9590 - 9989
Lung and Bronchus	C34.0 - C34.9	all except 9590 - 9989
Melanoma of Skin	C44.0 - C44.9	8720 - 8790
Multiple Myeloma	C00.0 - C80.9	9731, 9732, 9734
Non-Hodgkin Lymphoma	C00.0 - C80.9 All except C42.0, C42.1, C42.4	9590 - 9595, 9670 - 9729 9823, 9827
Oral Cavity and Pharynx	C00.0 - C14.8	all except 9590 - 9989
Ovary	C56.9	all except 9590 - 9989
Pancreas	C25.0 - C25.9	all except 9590 - 9989
Prostate	C61.9	all except 9590 - 9989
Stomach	C16.0 - C16.9	all except 9590 - 9989
Testis	C62.0 - C62.9	all except 9590 - 9989
Thyroid	C73.9	all except 9590 - 9989
Uteri, Corpus and Uterus, NOS	C54.0 - C54.9, C55.9	all except 9590 - 9989
All Sites / Types	C00.0 - C80.9	8000 - 9989

[1] includes codes added to the *International Classification of Diseases for Oncology, Third Edition* since its publication.

[2] Only invasive cancers (those with invasive behaviors) are included in this publication except Bladder, Urinary. Non-invasive (*in situ*) cancers are not included.

[3] Massachusetts hospital coding conventions may have assigned some cases to a "not otherwise specified" site category that is not included in this cancer type.

APPENDIX II: RISK FACTORS FOR SELECTED CANCER TYPES AND REVIEWERS OF RISK FACTORS

This Appendix contains a list of risk factors for thirteen types of cancer. The list briefly summarizes available information from the scientific literature. The list was last revised in 2000. Cancers are complex diseases, many of which have multiple factors that may contribute to their development. It should be noted that there is no single agreed-upon list of risk factors -- even the experts may disagree. This list should be viewed only as a starting point for the interested reader, and should not be viewed as constituting a definitive or comprehensive summary of cancer risk factors. Future risk factor lists may change as new research findings emerge.

The list separates those characteristics for which research clearly indicates a strong association in the development of the cancer ("Risk Factors") from those characteristics for which weaker associations exist ("Possible Risk Factors") or which are now coming under investigation ("Under Investigation").

For additional information on cancer risk factors or prevention, you may wish to contact the following:

Cancer Information Service (National Cancer Institute): 1-800-4-CANCER
Cancer Response Line (American Cancer Society): 1-800-ACS-2345

In addition, the following selected Internet websites provide information on cancer. Many of these also provide links to other sites (not listed) which may be of interest.

Massachusetts Department of Public Health: http://www.state.ma.us/dph

American Cancer Society: http://www.cancer.org

Centers for Disease Control and Prevention
Home Page: http://www.cdc.gov
Cancer Prevention and Control Program: http://www.cdc.gov/cancer

National Cancer Institute
Information: http://www.cancer.gov
CANCERLIT® (literature): http://www.cancer.gov/search/cancer_literature
SEER data: http://seer.cancer.gov
5-A-Day Program (nutrition): http://www.5aday.gov

Harvard Center for Cancer Prevention
Home Page: http://www.hsph.harvard.edu/cancer
Your Cancer Risk: http://www.yourcancerrisk.harvard.edu

OncoLink (University of Pennsylvania Cancer Center): http://www.oncolink.upenn.edu

Cancer News on the Net® (information on diagnosis and treatment for cancer patients and their families): http://www.cancernews.com

National Coalition for Cancer Survivorship: http://www.canceradvocacy.org

BLADDER, URINARY

Risk Factors:

- Age (In Massachusetts, incidence rates increase markedly in the 65 to 74 year age group, and are highest in the 75 years and older age groups.)
- Cigarette smoking
- Excessive use of certain pain medications such as those containing phenacetin
- Treatment with alkylating agent chemotherapy drugs such as Cytoxan (cyclophosphamide)
- Having had radiation therapy to the bladder

Possible Risk Factors:

- Occupations in which workers are suspected of having an elevated bladder cancer risk due to certain chemical exposures include working in the rubber and/or leather industries, dye manufacturing, painters, professional drivers of trucks and other motor vehicles, aluminum workers, machinists, chemical workers, printers, metal workers, hairdressers and textile workers
- Urologic conditions such as urinary tract infections and urinary stasis
- Dietary factors

BREAST

Risk Factors:

- Age (In Massachusetts, incidence rates increase markedly in the 45 to 64 year age group, and are highest in the 75 years and older age groups.)
- Family (mother, sister or daughter) history of breast cancer, especially if it was detected pre-menopausally (before the change of life)
- High-dose radiation therapy to the chest, especially from age 11 until age 30
- Never giving birth
- First childbirth after age 30
- Menstruating since age 12 or younger
- Late age (older than 55) at menopause (change of life)
- Having inherited a mutation in breast cancer susceptibility genes such as BRCA1 or BRCA2
- Increasing body fat in post-menopausal women
- Estrogen taken post-menopausally (after the change of life)
- More than three alcoholic drinks per day

Possible Risk Factors:

- Diet low in fruits and vegetables

Under Investigation:

- Pesticide exposure
- Other environmental exposures

CERVIX UTERI (cervical cancer)

Risk Factors:

- Age (In Massachusetts, incidence rates are highest in the 45 years and older age groups.)
- Certain types of human papilloma virus (HPV, the virus that causes genital warts)
- Sexual intercourse before age 19
- Multiple sexual partners
- Unprotected intercourse (having sex without a condom)
- Smoking
- Infection with HIV (human immunodeficiency virus, the virus that causes AIDS)

Possible Risk Factors:

- Too little vitamin A, vitamin C and/or folic acid in the diet
- Exposure to secondhand smoke (other people's smoke)

Use of the medication *diethylstilbestrol (DES)* during pregnancy is associated with later vaginal clear cell adenocarcinoma (a form of cervical and vaginal cancer) in the female children of those pregnancies.

COLON / RECTUM

Risk Factors:

- Age (In Massachusetts, incidence rates increase markedly in the 45 to 64 year age group, and continue to increase markedly in the 65 to 74 year and 75 to 84 year age groups.)
- A personal history of colorectal polyps or colorectal cancer
- Family history of colorectal cancer or polyps, including the various polyposis syndromes such as familial adenomatous polyposis, Gardner's Syndrome or Peutz-Jeghers Syndrome
- Personal history of inflammatory bowel disease such as ulcerative colitis or Crohn's Disease
- Personal history of ovarian, breast or endometrial cancer
- Diet high in red meat, and low in fruits, vegetables and folic acid
- Physical inactivity

Possible Risk Factors:

- Alcohol, especially beer
- Smoking
- Increasing body fat

LEUKEMIA

Risk Factors:

- Exposure to ionizing radiation
- Exposure to benzene
- Treatment with chemotherapy drugs (especially alkylating agents)
- Certain genetic conditions such as Down's syndrome
- Exposure to ethylene oxide

Possible Risk Factors:

- Exposure to low level solvent and metal mixtures
- Smoking

Under Investigation:

- Exposure to electromagnetic fields (e.g., from power lines)

LUNG AND BRONCHUS

Risk Factors:

- Smoking

  Note: 85% of all lung cancers are caused by smoking. The risk of lung cancer is *10 times greater* for persons who smoke up to one pack of cigarettes a day and *20 times greater* for persons who smoke more than one pack of cigarettes a day than for persons who do not smoke.
- Occupational, and in some cases environmental, exposures (e.g., asbestos, metals)
- Exposure to secondhand smoke (other people's smoke)

MELANOMA OF SKIN

Note: *changing or changed moles*, or *new moles which appear after age 30 that itch and are tender* are early, potentially malignant lesions, and should be examined by a health care professional.

Risk Factors:

- Age (In Massachusetts, incidence rates begin to increase markedly in the 45 to 65 year age group, and are highest in the 75 to 84 year age group.)
- One or more large or unevenly colored lesions such as:
  - Dysplastic mole(s), with or without a family history of melanoma
  - Lentigo maligna
- Familial atypical mole and melanoma syndrome
- Giant congenital melanocytic nevi (pigmented patches of skin)
- Nevus (birthmark) since birth
- Caucasian
- Previous melanoma
- Family history of melanoma
- Immunosuppression (when the body's defenses are weakened, such as after transplant surgery)
- Sun sensitivity
- Repeated sunburns, especially as a child
- Easily sunburned
- Freckling
- Unable to tan easily

NON-HODGKIN'S LYMPHOMA (now known as non-Hodgkin lymphoma)

Risk Factors:

- Age (In Massachusetts, incidence rates begin to increase in the 45 to 65 year age group, and are highest in the 75 to 84 year age group.)
- Abnormalities of the immune system, either congenital or resulting from suppression due to organ transplantation or disease
- Infection with HIV (human immunodeficiency virus, the virus that causes AIDS)
- Exposure to radiation or chemotherapy
- Exposure to certain herbicides

Possible Risk Factors:

- Smoking
- Other chemical exposures

ORAL CAVITY AND PHARYNX

Risk Factors:

- Tobacco use (including cigarettes, pipes, cigars, chewing tobacco and snuff)
- Heavy alcohol use
- Age (In Massachusetts, incidence rates begin to increase in the 45 to 64 year age group, and are highest in the 75 to 84 year age group.)
- Poor nutrition, especially chronic iron deficiency

Possible Risk Factors:

- Chronic irritation of the mouth due to ill-fitting dentures or broken teeth
- Poor oral hygiene

OVARY

Risk Factors:

- Age (In Massachusetts, incidence rates increase markedly in the 45 to 64 year age group, and are highest in the 65 to 74 year age group.)
- Never giving birth
- Personal history of endometrial (lining of the uterus), colon or breast cancer
- Family history of ovarian cancer (mother, sister or daughter)
- Having one of three inherited ovarian cancer conditions:
  - breast-ovarian cancer syndrome
  - site-specific ovarian cancer syndrome
  - hereditary nonpolyposis colorectal cancer or Lynch II syndrome (includes early-onset colorectal cancer, endometrial cancer, breast cancer and ovarian cancer)
- Never having used oral contraceptives, or having used oral contraceptives for fewer than five years
- Caucasian

Possible Risk Factors:

- Fertility drugs
- Use of talc powder containing asbestos fibers in the perineal or external genitalia area
- High fat diet

PROSTATE

Risk Factors:

- Age (In Massachusetts, incidence rates begin to increase markedly in the 45 to 64 year age group, and are highest in the 65 to 74 year age group.)
- Family history of prostate cancer
- Hormonal factors
- African-American

Possible Risk Factors:

- Alcohol consumption
- Having a history of benign prostate disease
- Smoking
- Physical inactivity
- Diet high in fat

TESTIS

Risk Factors:

- Age (In Massachusetts, incidence rates are highest in the 20 to 44 year age group.)
- Undescended testicle

Possible Risk Factors:

- Inguinal hernia
- Testicular trauma
- Familial factors
- Occupations related to leather processing

UTERI, CORPUS AND UTERUS, NOS (uterine cancer)

Risk Factors:

- Age (In Massachusetts, incidence rates are highest in the 45 years and older age groups.)
- Personal history of colon and/or breast cancer
- Family history of uterine cancer
- Being more than 20 pounds overweight
- Never giving birth
- Presence of estrogen-producing ovarian tumors
- Postmenopausal (change of life) use of estrogen without progesterone
- Tamoxifen (a drug given to women who have had breast cancer to lower the risk of recurrence)
- Late age (older than 55) at menopause (change of life)

Possible Risk Factors:

- Diet high in fatty foods
- Hypertension (high blood pressure)
- Diabetes (high blood sugar)
- Chronic anovulation (ovaries do not produce eggs)
- Menstrual problems
- Radiation therapy to the pelvis
- Malignant tumors on the ovaries
- Never having used oral contraceptives, or having used oral contraceptives for fewer than five years

Reviewers of Risk Factors

This Appendix was assembled under the auspices of the American Cancer Society (New England Division) through seeking the advice of leading cancer experts. The following clinicians, researchers and public health professionals reviewed the risk factors for the type(s) of cancers indicated:

Ross Berkowitz, MD (ovarian, uterine)

Cynthia Boddie-Willis, MD, MPH (prostate)

Risa Burns, MD (breast, cervical)

Richard Clapp, ScD (all types)

Graham Colditz, DrPH (colorectal)

Suzanne Condon, MS (all types)

Greg Connolly, DMD (lung)

Daniel Cramer, MD (ovarian)

Letitia Davis, ScD (all types)

Catherine DuBeau, MD (prostate)

Kathleen Egan, PhD (breast)

Richard Fabian, MD (oral)

Marc Garnick, MD (prostate, testicular)

Alan Geller, RN, MPH (melanoma)

Annekathryn Goodman, MD (uterine)

Lauren Holm, RN, MSN (all types)

David Hunter, MD, BS, ScD (all types)

Joe Jacobson, MD (prostate)

Phil Kantoff, MD (bladder, prostate)

Howard Koh, MD, MPH (melanoma)

Robert Krane, MD (testicular)

Frederick Li, MD (all types)

John Lisco, MPH (colorectal)

Robert Mayer, MD (colorectal)

Kenneth Miller, MD (leukemia)

Michael Monopoli, DMD (oral)

Nancy Mueller, ScD
(non-Hodgkin's lymphoma)

J. David Naparstek, ScM, CHO (all types)

Robert Osteen, MD (breast)

James Petros, MD (colorectal)

Marianne Prout, MD, MPH (all types)

Lowell Schnipper, MD
(non-Hodgkin's lymphoma)

Paul Schroy, MD, MPH (colorectal)

Ellen Sheets, MD (cervical)

William Shipley, MD (bladder)

Art Skarin, MD (lung)

Arthur Sober, MD (melanoma)

Bonnie Tavares, MEd (breast, cervical)

Howard Weinstein, MD (leukemia)

Martha Crosier Wood, MBA (all types)

and staff members of the Massachusetts Department of Public Health's Center of Environmental Health Assessment (all types), Colorectal Cancer Working Group (colorectal), Skin Cancer Prevention Program (melanoma), and Massachusetts Women's Health Network (breast, cervical).

We would also particularly like to thank Lauren Holm, former Vice President for Planning and Evaluation, American Cancer Society (New England Division) and Martha Crosier Wood, former Director, Comprehensive Cancer Prevention and Control, Massachusetts Department of Public Health for their assistance in the development of this Appendix.

APPENDIX III: MDPH CANCER CONTROL INITIATIVES AND PUBLICATIONS

This Appendix was developed by the Comprehensive Cancer Prevention and Control Program of the Bureau of Family and Community Health, Massachusetts Department of Public Health (MDPH). The MDPH is working to reduce the incidence and mortality of cancer throughout the Commonwealth. The following is a description of some of the current efforts to reduce the risk of specific cancers. For further information about specific cancers or cancer-related programs and issues, please contact the Comprehensive Cancer Prevention and Control Program at 617-624-5480.

BLADDER CANCER

The incidence of bladder cancer increases with age and is three times more common in men than in women. Smoking appears to double a person's risk of bladder cancer.

MDPH is currently working to reduce the incidence of bladder cancer through the following activities:

- initiating an extensive program of tobacco-control activities. For specific activities, refer to the strategies of the Massachusetts Tobacco Control Program as listed under the section for *Lung Cancer*;
- developing statistical publications, such as *Selected Cancers in Massachusetts Men 1982-1996,* which include information on bladder cancer.

BREAST CANCER

Breast cancer is the most common cancer in women in Massachusetts and throughout the United States.

In 1992, MDPH launched a breast and cervical cancer screening program for uninsured and underinsured eligible women in order to detect these diseases when they are most treatable. In addition, in 1992 the state legislature allocated moneys for a breast cancer research program. Funding for research increased in subsequent years however, the research program was eliminated in 2002 due to state budget cuts.

MDPH is currently involved in numerous activities to address breast cancer in Massachusetts, including:

- providing free mammograms and clinical breast examinations for uninsured and underinsured eligible women via the Massachusetts Women's Health Network;
- developing and disseminating materials on the Massachusetts Women's Health Network, especially for low-literacy, culturally diverse, and non-English speaking women;
- training community health outreach workers on communicating risk factors and screening options with culturally and ethnically diverse populations;
- enhancing clinical and diagnostic skills of clinicians throughout Massachusetts by providing continuing education training;
- providing continuing education for mammography technologists;
- promoting public and professional awareness of issues related to the genetics of breast cancer;
- working to reduce possible risk factors associated with breast cancer such as poor nutrition and lack of physical activity;
- providing a clearinghouse of publications concerning breast cancer;
- developing statistical publications, such as *Cancer in Massachusetts Women 1989-1998,* which include information on breast cancer.

CERVICAL CANCER

Cancer of the cervix uteri is highly curable when detected at an early, pre-invasive stage.

MDPH is currently involved in the following cervical cancer prevention and control activities:

- providing free Pap tests for uninsured and underinsured eligible women and teens via the Massachusetts Women's Health Network and Family Planning programs;
- training community health outreach workers on communicating risk factors and screening options with culturally and ethnically diverse populations;
- educating medical professionals on counseling patients about cervical cancer and performing cervical cancer screenings;
- working to reduce the risk of cervical cancer associated with exposure to tobacco smoke and sexually transmitted diseases;
- providing continuing education for cytotechnologists on cervical cytology;
- developing statistical publications, such as *Cancer in Massachusetts Women 1989-1998*, which include information on cervical cancer;
- providing a clearinghouse of publications concerning cervical cancer;
- implementing prevention programs to address viral sexually transmitted diseases, such as HPV, herpes virus and HIV infection.

COLORECTAL CANCER

Colorectal cancer is the second leading cause of cancer death in Massachusetts. It may be prevented through lifestyle changes including a healthy diet, increased physical activity, and tobacco cessation. Both incidence and mortality from colorectal cancer can be greatly decreased through routine screening and early detection.

To reduce the burden of this disease, MDPH formed the Massachusetts Colorectal Cancer Working Group in partnership with the American Cancer Society, University of Massachusetts Medical School, Dana-Farber Cancer Institute, Harvard School of Public Health, Boston University School of Medicine, and others.

MDPH is working to reduce the incidence of colorectal cancer through the following activities:

- co-sponsoring workshops and continuing medical education events for health care professionals;
- distributing information on colorectal cancer prevention and screening to health care professionals in the Commonwealth;
- developing statistical publications, such as *Data Report on Colorectal Cancer in Massachusetts, Selected Cancers in Massachusetts Men 1982-1996* and *Cancer in Massachusetts Women 1989-1998*, which include information on colorectal cancer;
- producing public information posters and brochures in a variety of languages, including *You Can Prevent Colorectal Cancer* and *Take Control: Get Tested for Colorectal Cancer*, which are available to individuals through the Massachusetts Health Promotion Clearinghouse;
- Conducting surveys to determine Massachusetts health care providers' knowledge, perceptions, and screening practices regarding colorectal cancer;
- increasing public understanding of colorectal cancer risk factors;
- conducting community outreach projects in various regions of the state, consisting of workshops, health fair displays and media campaigns targeted at adults age 50 and older.

LUNG CANCER

Lung cancer is the leading cause of cancer death for both men and women. Despite high incidence and mortality rates and the lack of screening tests, lung cancer is a largely preventable disease. Since 85% of lung cancers can be attributed to cigarette smoke, the most effective strategy for preventing lung cancer is through tobacco control. Several prospective studies show that a former smoker's risk of developing lung cancer can be reduced by half within five years. The risk of lung cancer from smoking may be augmented by other factors including exposure to carcinogens.

MDPH, mainly through the Massachusetts Tobacco Control Program, is working to reduce the risk of lung cancer through the following activities:

- helping smokers quit smoking through statewide services including the Try to Stop Tobacco Resource Center's telephone helpline (1-800-trytostop), website (www.trytostop.org), and educational print materials;
- providing training to healthcare providers on basic skills for smoking cessation and patient interventions;
- Utilizing QuitWorks program (www.QuitWorks.org) to provide health care clinicians with a simple approach to treating their patients who smoke by linking them to proactive telephone counseling and the state's range of effective tobacco treatment services;
- providing funding and training to local boards of health to promote and enforce local regulations that reduce youth access to tobacco products;
- implementing the Massachusetts Smoke-free Workplace Law (effective July 5, 2004) including a complaint and information line 1-800-992-1895 and providing training to local boards of health on enforcement issues;
- raising public awareness about the health issues related to tobacco use and the need for tobacco control public policy initiatives through community-based Tobacco Free Community Mobilization Networks;
- measuring changes in adult and youth attitudes toward tobacco use;
- developing statistical publications, such as *Selected Cancers in Massachusetts Men 1982-1996* and *Cancer in Massachusetts Women 1989-1998,* which include information on lung cancer;
- conducting public awareness programs around the risk of lung cancer that is associated with exposure to radon gas;
- researching possible environmental links to lung cancer.

ORAL CANCER

Tobacco (cigarettes, smokeless/chew) and excessive alcohol use are the greatest risk factors for oral cancer. However, poor nutrition, poor oral hygiene, and chronic irritation of the mouth due to ill-fitting dentures or broken teeth also play a role. Early detection of oral cancer can significantly reduce morbidity and mortality.

MDPH, in partnership with the Boston University School of Dental Medicine, Harvard School of Dental Medicine, Tufts University School of Dental Medicine, Forsythe Institute, American Cancer Society, and Massachusetts Dental Society, has formed the Oral Cancer Partnership and is currently involved in reducing the risk of oral cancer through the following activities:

- educating the public about oral cancer through outreach and distribution of educational materials;
- educating dentists and dental hygienists on the importance of performing yearly oral cancer screenings on populations at high risk for oral cancer;
- educating primary care providers involved with populations at high risk for oral cancer;
- promoting tobacco cessation through quitline initiatives;

- initiating an extensive program of tobacco-control activities. For specific activities, refer to the strategies of the Massachusetts Tobacco Control Program as listed under the section for *Lung Cancer*;
- developing statistical publications, such as *Selected Cancers in Massachusetts Men 1982-1996*, which include information on oral cancer.

OVARIAN CANCER

Ovarian cancer is the fourth most frequent cause of cancer death in women in the United States. It is curable when detected early. However, because there is no general screening method, and it has no symptoms in its early stages, ovarian cancer often goes undetected. MDPH, in partnership with the Massachusetts Division of the National Ovarian Cancer Coalition, the Ovarian Cancer Education and Awareness Network (OCEAN), the Rendon Group, Massachusetts General Hospital Cancer Center, M. Patricia Cronin Foundation to Fight Ovarian Cancer, Harvard Medical School, Dana-Farber Cancer Institute, and Brigham and Women's Hospital, has formed the Massachusetts Ovarian Cancer Awareness Partnership and is currently involved in raising awareness of ovarian cancer through the following activities:

- promoting public and professional awareness of issues related to ovarian cancer;
- promoting public awareness of how to decrease the risk of ovarian cancer through the Massachusetts Women's Health Network, Women, Infants and Children (WIC) and Family Planning;
- developing statistical publications, such as *Cancer in Massachusetts Women 1989-1998*, which include information on ovarian cancer.

PROSTATE CANCER

Prostate cancer is the most common cancer in men in Massachusetts, with the exception of skin cancer. MDPH, in partnership with the Massachusetts Prostate Cancer Coalition, and community based partnership organizations works to reduce prostate cancer incidence and mortality and to address issues of quality of life for prostate cancer survivors and their families. The following MDPH activities are currently underway to address prostate cancer:

- increasing knowledge and awareness among men and their families about prostate cancer through a variety of community-based programs and media strategies;
- developing and distributing educational materials about prostate cancer that are culturally sensitive and available in several (six) languages and at varying literacy levels;
- linking uninsured and underinsured men with medical care, including prostate cancer screening through thirteen Men's Health Partnership sites;
- funding prostate cancer survivor support groups across Massachusetts;
- developing statistical publications, such as *Selected Cancers in Massachusetts Men 1982-1996*, which include information on prostate cancer;
- co-sponsoring an annual prostate cancer symposium;
- providing publications concerning prostate cancer through the Massachusetts Health Promotion Clearinghouse;
- co-sponsoring trainings for health care outreach workers and health care professionals.

SKIN CANCER (INCLUDING MELANOMA)

Skin cancer is the most common and preventable form of cancer in the United States. Almost all skin cancers are curable if detected and treated early, before they have spread to other tissues. Exposure to ultraviolet radiation, most frequently from the sun but also from tanning beds and booths, is the primary cause of skin cancer.

MDPH, in partnership with the American Cancer Society, Boston University School of Medicine, the Dana-Farber Cancer Institute, the Harvard School of Public Health, the Massachusetts Melanoma Foundation, and other organizations and individuals, have formed the Massachusetts Skin Cancer Prevention Collaborative to address skin cancer in Massachusetts.

MDPH is currently involved in the following activities to prevent skin cancer:

- assisting communities developing local skin cancer prevention programs;
- helping summer camps, child care centers, and schools develop programs and policies to prevent skin cancer;
- training child care workers on safe sun practices;
- developing and distributing skin cancer prevention materials including tip cards and posters;
- increasing awareness among health professionals;
- developing statistical publications, such as *Selected Cancers in Massachusetts Men 1982-1996* and *Cancer in Massachusetts Women 1989-1998*, which include information on melanoma, the most deadly form of skin cancer;
- exploring other venues of recreational exposure, including Little Leagues.

TESTICULAR CANCER

Testicular cancer accounts for 1% of all cancers in Massachusetts males. In Massachusetts, testicular cancer is the most common cancer in men ages 20 to 44.

Massachusetts is currently working to reduce the risk of testicular cancer through the following efforts:

- developing and distributing testicular cancer public and professional information materials;
- developing statistical publications, such as *Selected Cancers in Massachusetts Men 1982-1996*, which include information on testicular cancer.

UTERINE CANCER

There is currently no screening test for uterine cancer. The Pap smear, which is used to detect cervical cancer, finds fewer than half of endometrial (uterine) cancers.

MDPH is currently working to address uterine cancer through the following activities:

- providing information concerning uterine cancer through the Massachusetts Women's Health Network and Family Planning programs;
- developing statistical publications, such as *Cancer in Massachusetts Women 1989-1998*, which include information on uterine cancer.

Cancer-Related Publications from the Massachusetts Department of Public Health (MDPH)

General Cancer
The following materials are available through the Massachusetts Health Promotion Clearinghouse, telephone 1-800-952-6637, website www.maclearinghouse.com:
Cancer Screening Can Save Your Life *(tip sheet, available in English)*

Breast and Cervical Cancer
The following materials are available through the Massachusetts Health Promotion Clearinghouse, telephone 1-800-952-6637, website www.maclearinghouse.com:
Bilingual Mammography Patient's "Bill of Rights" *(information card, available in English/Spanish)*
Bilingual Mammography Patient's "Bill of Rights" *(poster, available in English/Spanish)*
Massachusetts Breast Cancer Research Program *(booklet for researchers)*
They Say The Best Things In Life Are Free *(poster)*
What You Should Know about Breast Cancer *(brochure, available in English, Spanish, Portuguese, Haitian Creole, Vietnamese, and Chinese)*
What You Should Know about Cervical Cancer *(brochure, available in English, Spanish, Portuguese, Haitian Creole, Vietnamese, and Chinese)*
The following materials are available through Massachusetts Department of Public Health Women's Health Network, telephone 1-877-414-4447:
Women's Health Network Bilingual Information Card *(eligibility criteria and contact information for free health screening, available in Chinese, English, Haitian Creole, Khmer, Lao, Portuguese, Russian, Spanish, Vietnamese)*
Bilingual Women's Health Network *(wallet card)*
Women's Health Network Passport Health Guide *(booklet, available in English, Spanish, Portuguese, Chinese, and Vietnamese)*
Women's Health Network Program Point of Purchase Display *(stand with tear-off cards)*
You are the difference (*video, 12:55 min, in English, promotes the importance of regular screenings and includes personal accounts from women who have participated in WHN, #BC083).*

Colorectal Cancer
The following materials are available through the Massachusetts Health Promotion Clearinghouse, telephone 1-800-952-6637, website www.maclearinghouse.com:
If You Remember the First Color TV, Get Tested for Colon Cancer *(bookmark for adults age 50 and older, available in English)*
Colorectal Cancer Prevention *(laminated reference card for health care professionals, available in English)*
Take Control:Get Tested for Colorectal Cancer *(public brochure, available in Chinese, English, French, Portuguese, Russian, Spanish, and Vietnamese)*
You Can Prevent Colorectal Cancer *(public brochure, available in Chinese, English, French, Khmer, Portuguese, Russian, Spanish, and Vietnamese)*

Oral Cancer
The following materials are available through the Massachusetts Health Promotion Clearinghouse, telephone 1-800-952-6637, website www.maclearinghouse.com:
Don't Be Afraid to Say Ahh… *(public brochure, available in English, Chinese, Portuguese, Russian, and Spanish)*

Ovarian Cancer
To order any of these pamphlets, send requests via mail or fax to:
National Ovarian Cancer Coalition, Inc.
500 NE Spanish River Blvd, Ste 14
Boca Raton, FL 33431-4516
main telephone: 561-393-0005, fax 561-393-7275
information line: 1-888-682-7426 (1-888-OVARIAN)
website: www.ovarian.org
Myths & Facts about Ovarian Cancer. What You Need to Know (2nd ed.)
by M. Steven Piver, MD and Gamal Eltabbakh, MD
National Ovarian Cancer Coalition. Working to Raise Awareness About Ovarian Cancer Risks and Symptoms
Ovarian Cancer…It Whispers…So Listen
Patient to Patient *(patient resource for women with ovarian cancer)*
What Every Woman Should Know About Ovarian Cancer
Ovarian Cancer Reference Card (*a wallet- sized card that provides facts, symptoms and resources*)

Prostate Cancer
The following materials are available through the Massachusetts Health Promotion Clearinghouse, telephone 1-800-952-6637, website www.maclearinghouse.com:
What Every Man Should Know About Prostate Cancer *(public brochure, available in Chinese, English, Haitian Creole, Portuguese, Russian, and Spanish)*
Prostate Cancer Fact Sheet *(fact sheet available in English, Spanish, and Portuguese)*
What You Learn about Prostate Cancer May Save Your Life *(poster, available in English and Spanish)*

Skin Cancer
The following materials are available through the Massachusetts Health Promotion Clearinghouse, telephone 1-800-952-6637, website www.maclearinghouse.com:
Ban the Burn Tip Sheet:General/Parents *(available in English, Portuguese, and Spanish)*
Ban the Burn Tip Sheet:Newborns *(available in English, Portuguese, and Spanish)*
Ban the Burn Tip Sheet:Preschool Children *(available in English, Portuguese, and Spanish)*
Every Day is a Sun Day *(calendar, available in English)*
Ban the Burn Temporary Tattoos
Ban the Burn Sneaker Sticker *(available in English)*
Ban the Burn Poster *(available in English)*
It's Never Too Late to Protect Yourself from Skin Cancer *(tip sheet for adults age 50 and older, available in English)*
Have a Changing Mole? *(poster, available in English)*
Have a Changing Mole? (*tip card for general public, available in English))*
Have a Changing Mole? (*laminated tip card for health care professionals, available in English)*

Nutrition
The following materials are available through the Massachusetts Health Promotion Clearinghouse, telephone 1-800-952-6637, website www.maclearinghouse.com:
5 A Day Resource Directory
African Americans Take the 5 A Day Challenge for Better Health *(brochure)*
Men Eat 9 A Day (*brochure in English for men of color*)
Smart Snacking Tastes Great (*brochure*)
Snack Your Way to 5 A Day (*brochure available in Spanish*)

Time to Take Five: Eat 5 Fruits and Vegetables A Day *(brochure)*
5 A Day Recipe Cards *(set of 10 cards)*
Color Way Pocket Guide (*brochure or wallet card*)
Best and Worst Fast Food (*set of 3 fact sheets*)
Eat 5 Fruits and Vegetables A Day for Health and Energy *(poster for youth)*
5 A Day Easily Fits Your Schedule (*poster*)

Physical Activity
The following materials are available through the Massachusetts Health Promotion Clearinghouse, telephone 1-800-952-6637, website www.maclearinghouse.com:
Physical Activity Fact Sheets *(reproducible facts sheets from the American Council on Exercise)*
A Small Investment with a Big Payoff! (*tip card*)
Activity Pyramid (*brochure*)

Tobacco
Materials on smoking cessation, secondhand smoke and preventing youth initiation to tobacco products may be ordered from:
Try-to-Stop Tobacco Resource Center
JSI Research and Training Institute, Inc.
44 Farnsworth St
Boston, MA 02122-1211
telephone: 617-482-9485, fax: 617-482-0617
e-mail: mtec@jsi.com
The Try-to-Stop Tobacco Resource Center offers education pamphlets, booklets, signs, posters, fact sheets and other items. Tobacco information and cessation materials are available in ten languages. You may obtain a copy of the current order form by contacting the Try-to-Stop Tobacco Resource Center at 617-482-9485.

Miscellaneous
Take Charge: Medicare Part B Benefits and You (*video, 15 min, in English, provides an overview of the screening benefits covered under Medicare Part B.Video is designed to increase awareness about the prevention benefits under Medicare Part B, and to increase screening rates for Medicare beneficiaries, # BC089).*

Other Massachusetts Cancer Registry Publications
The following materials are available through the Massachusetts Cancer Registry, telephone 617-624-5642:
Cancer Incidence and Mortality in Massachusetts – Statewide Report 1997-2001
Cancer in Massachusetts Women 1989-1998 Data Report
Childhood Cancer in Massachusetts 1990-1999
Selected Cancers in Massachusetts Men 1982-1996
Data Report on Colorectal Cancer in Massachusetts
Massachusetts Cancer Registry Public Information Brochure *(available in English, Portuguese, Spanish)*